COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
APPLICATION FOR RETROACTIVE EMERGENCY MEDICAL SERVICES

(COUNTY STAMP)

Case name: _____

Case number: _____

District: _____

Approval/denial for: _____

_____
(Names)

We have reviewed all the information in your case file which relates to your application for retroactive emergency medical services. Our findings are indicated below.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain which, in the absence of immediate attention, could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part. The emergency must be certified by a physician or other appropriate medical provider (in accordance with Section 51056, Title 22, California Code of Regulations). The Department of Health Services may review the provider's decision that an emergency existed and that certain follow-up treatment services were medically justified.

❒ You are entitled to receive CMSP benefits restricted to emergency services for_____.

❒ Since your income was more than the amount allowed for living expenses, you must pay or obligate to pay a share of the cost of your medical care.

Gross Income	$ _____
Net Nonexempt Income	$ _____
Maintenance Need	$ _____
Excess Income/Share-of-Cost	$ _____

❒ A plastic Benefits Identification Card (BIC) will be sent to you in the mail soon. TAKE THIS PLASTIC CARD TO EACH MEDICAL PROVIDER WHERE YOU RECEIVED SERVICE. Your plastic card will show your provider if you have a share-of-cost to pay. The amount that you pay or are obligated to pay the medical providers will be automatically computed. DO NOT THROW AWAY YOUR PLASTIC ID CARD.

❒ You are not entitled to receive CMSP benefits restricted to emergency services for _____ for the following reasons:

This action is required by California Code of Regulations, Title 17, Section(s) 1498 et seq.

This action does not affect your application for current and continuing CMSP. If you have any questions or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions over the telephone, in writing, or will make an appointment to see you in person.

_____ Eligibility Worker

_____ Phone

_____ Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE